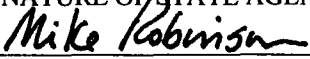



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 02-17	2. STATE Kentucky
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2002	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.20		7. FEDERAL BUDGET IMPACT: a. FFY 2003                      \$(420,000) b. FFY 2004                      \$(420,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B, Page 20.17		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 4.19-B, Page 20.17	
10. SUBJECT OF AMENDMENT: Outpatient surgical center reimbursement			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: Mike Robinson		Frances McGraw Eligibility Policy Branch Department for Medicaid Services 275 East Main Street 6W-C Frankfort, Kentucky 40621	
14. TITLE: Commissioner, Department for Medicaid Services			
15. DATE SUBMITTED: 12/12/02			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 12, 2002		18. DATE APPROVED: March 11, 2003	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2002		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Rhonda R. Cottrell		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

State: Kentucky

XVIII. Outpatient Surgical Centers

The Department shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio-Kentucky region to reimburse for an outpatient surgical center service. Following is a chart which states the reimbursement rate for each corresponding surgical group:

ASC Group	Reimbursement Rate
Group 1	\$307.38
Group 2	\$412.79
Group 3	\$471.90
Group 4	\$582.25
Group 5	\$664.02
Group 6	\$775.59
Group 7	\$921.15
Group 8	\$911.55

Procedures that are not included in one (1) of the eight (8) Medicare surgical groups, reimbursement shall be on the basis of forty-five (45) percent of the center's usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical centers shall be reimbursed in the same manner as hospital outpatient services.